

PATIENT MEDICAL HISTORY

Patient Name _____ DOB _____ Age _____ Date _____

Name of your Primary Care Physician _____

CHIEF COMPLAINT (Be specific as to why you are seeing Dr. Mabray)

ALLERGIES TO MEDICATIONS

HEALTH HISTORY (**circle** those you have been diagnosed with)

Check box if NO CHANGES

For established patients ONLY

Diabetes	Tuberculosis	Epilepsy	Endometriosis	Hepatitis	Heart Murmur	Heart Disease	
Mono	Seizures	High BP	Migraines	Asthma	Anemia	Stroke	Cancer

OTHER SYMPTOMS (please **circle** your symptoms)

Headaches	Tire easily	Get cold easily	Change in weight	Change in bowels
Blood in stools	Trouble sleeping	Coughing	Swelling	Vomiting
Nausea	Dizziness	Blurred vision	Chest pain	Heartburn/indigestion
Short of breath	Free bleeding	Yellow skin/eyes	Weakness	Irregular heartbeat
Depression	Loss of hearing	Oral infections	Joint pain	Loss of sexual desire
Blood transfusion	Glasses/contacts	Dentures/appliance	Constipation	Ringing in ears
Loss of hair	Muscle pain	Difficulty breathing	Open sores, lacerations or abrasions	

BLADDER SYMPTOMS (**circle** if any)

Low back pain	Frequency of urination	Frequent bladder infections
Burning/Stinging with urination		Take medication for bladder control

FAMILY HISTORY (write Mother, Father, Sister, Brother or Child, SKIP if adopted)

Check box if NO CHANGES

For established patients ONLY

Ovarian Cancer _____	Hypertension _____	Stroke _____
Breast Cancer _____	Diabetes _____	Melanoma _____
Cervical Cancer _____	Uterine Cancer _____	Colon Cancer _____
Thyroid Disease _____	Osteoporosis _____	Other _____

HEALTH RISKS

Do you smoke? Y/N If yes, how many packs a day? _____ Do you drink alcohol? Y/N If yes, how often? _____
Do you abuse prescription/illicit drugs? Y/N Is work/school ok? Y/N
Do you diet excessively, starve or make yourself vomit? Y/N
Do you excessively expose your skin (sunbathing, tanning booths)? Y/N
Are you sexually active? Y/N Number of partners? _____

**PLEASE COMPLETE THE BACK SIDE
OF THIS PATIENT MEDICAL HISTORY FORM**

PATIENT NAME/DOB _____

Have you been out of the U.S. in the last 24 months? Y/N Have you had flu-like symptoms? Y/N

Have you had recurring fevers? Y/N

How much did you weigh at birth? _____ At age 18? _____

List any foods that bother you _____

Have you had any injuries or broken bones? Y/N When? _____

Past surgeries (list procedures and dates) **Check here if NO CHANGES for established patients ONLY**

IMMUNIZATIONS (mark if you have had a booster in the past 10 years)

Tetanus _____ MMR _____ Flu shot _____

TB Test _____ Hepatitis B _____

Pneumonia Shot _____ Varicella (chicken pox) _____

Gardasil (HPV) _____ Zostavax (Shingles) _____

MENSES

Age when periods started? _____ Date of last period (month and day) _____

Are your periods regular? _____ How many days apart? _____

Are your period's heavy? _____ How many days do they last? _____

Do you have bad cramps? Y/N Rank pain from 1 (not bad) to 10 (worst) _____

Does medication help? Y/N What do you take? _____

Headaches with period? Y/N What do you take? _____

Do you use birth control? Y/N What method? _____

Total # of pregnancies _____ (=) number of living children _____ (+) number of miscarriages/abortions _____

Age and sex of youngest child _____ Significant complications _____

VAGINAL/VULVAR SYMPTOMS (circle)

Itching Burning Pain with intercourse Bleeding with intercourse Vaginal dryness

List additional symptoms: _____

BREAST SYMPTOMS (circle)

Breast pain Nipple discharge Breast lump Change in skin appearance

List additional symptoms: _____

Do you do regular self breast exams? Y/N Have you had a mammogram? Y/N Date of exam _____

ABUSE: National statistics indicate that 14-17% of women are abused at some time in their life. Abuse takes many forms: sexual, physical, verbal and mental. It involves people of all ages. Out of respect for your privacy, we do not ask for a yes or no answer here. Please, if you need help, talk with Dr. Mabray in private.